

NEW PATIENT REGISTRATION FORM INFORMATION SHEET

Please refer to this information sheet to assist in filling out the Medical History section of the New Patient Registration Form.

Medical History

Please list all medical conditions and the year of diagnosis. Conditions include but are not limited to the following:

- Diabetes
- High blood pressure
- High cholesterol
- Heart disease (heart attack/heart failure/valve problems/angina
- Stroke/TIA
- Blood clot (leg/lungs)
- Peripheral vascular disease
- Anemia
- Asthma/COPD/emphysema/chronic bronchitis
- Other lung problems
- Major childhood illness
- Cancer
- Cancer treatment (surgery/radiation/chemotherapy)
- Kidney stones/kidney failure
- Urinary incontinence/prolaspsed bladder
- Gynecological conditions

 (endometriosis/fibroids/cysts/abnormal
 PAP/sexually transmitted disease

- Erectile dysfunction/enlarged prostate/sexually transmitted diseases
- Headaches/migraines
- Eye conditions (cataracts, glaucoma)
- Neurological (seizures, MS, paralysis, brain injury)
- Skin conditions: eczema,/psoriasis, skin cancers
- Upper GI: heartburn/reflux/ulcers/gallstones
- Lower GI: Crohn's/colitis/IBS
- Diverticulitis/hemorrhoids
- Arthritis: rheumatoid/osteoarthritis/gout/fibromyalgia/ lupus
- Osteoporosis/osteopenia
- Hypothyroid/hyperthyroid/nodules
- Joint, muscular problems
- Depression/anxiety/bipolar, schrizophrenia
- Addictions: alcohol/drugs/gambling

Medications & Dosage

Please list all current medications including over the counter medications and herbal remedies.

Surgical History

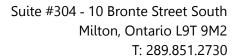
Please list any past surgeries and the approximate year/date in which they were performed and the surgeon's name where possible. This includes childhood surgeries such as appendectomies and tonsillectomies.

Family History

Please list family member's, age & year of diagnosis. Immediate family members would be parents/siblings/children/grandparents. Conditions include the following but are not limited to:

- heart disease/heart attack/heart surgery
- stroke
- cancer please list type
- osteoporosis/broken hip

- mental illness please list type
- suicide
- diabetes
- blood clot in lungs or legs (DVT/PE)





NEW PATIENT REGISTRATION FORM

Please return your completed form to Three Branches Medical at 10 Bronte Street South, Suite 304 or after hours, to Main & Bronte Pharmacy, Suite 102 on the main floor. Thank you.

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Personal	Intorn	STIAN
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First Name	Middle	Name	Last Name
Date of Birth (YYYY/MM/DD)	Ger	nder	Preferred Name (optional)
Health Card Number & Version Code			Expiry Date (YYYY/MM/DD)
Home Address		Conts	act Phone Numbers/Email
nome Address		Conta	act Phone Numbers/Email
		Mobile:	
		Home:	
		Email:	
Occupation	Marita	l Status	Children
Emergency Contact	Relation	n To You	Phone Number
Medical & Pharmacy			
Previous Family Physician	Addre	ss/City	Phone & Fax Number
Preferred Pharmacy	Addre	ss/City	Phone & Fax Number

Medical History	
	Medications & Dosage
Surgical History ———————————————————————————————————	Drug Allergies
Preventative Care:	Social History
Preventative Care: Please indicate the last date (YYYY/MM/DD) of the following: PAP:	Social History Smoking: [] Never smoked [] Previous smoker [] Current smoker No. cigarettes/day
Please indicate the last date (YYYY/MM/DD) of the following:	,
Please indicate the last date (YYYY/MM/DD) of the following: PAP:	Smoking: [] Never smoked [] Previous smoker [] Current smokerNo. cigarettes/day
Please indicate the last date (YYYY/MM/DD) of the following: PAP: Mammogram:	Smoking: [] Never smoked [] Previous smoker [] Current smokerNo. cigarettes/day Alcohol history: Number of drinks/week
Please indicate the last date (YYYY/MM/DD) of the following: PAP: Mammogram: Colonoscopy/Stool Test:	Smoking: [] Never smoked [] Previous smoker [] Current smokerNo. cigarettes/day Alcohol history: Number of drinks/week Any recreational drugs:
Please indicate the last date (YYYY/MM/DD) of the following: PAP: Mammogram: Colonoscopy/Stool Test: Tetanus Vaccine: Bone Density Scan:	Smoking: [] Never smoked [] Previous smoker [] Current smokerNo. cigarettes/day Alcohol history: Number of drinks/week Any recreational drugs: Caffeine Intake: Cups of coffee/day

Date: _____

Signature: _____